Health Maintenance Organization Regulations

Table of Contents

Regulations Governing The Operation of Health Maintenance Organizations To Be Promulgated By The Mississippi State Board of Health

Section A -- Statutory Authority

These regulations are promulgated pursuant to House Bill 276, adopted by the Mississippi State Legislature in its regular 1986 session, and pursuant to Mississippi Code Ann. SS41-3-17 (Supp. 1985).

Section B -- Definitions

1. "Commissioner" means the Commissioner of Insurance.

2. "Director" means the Executive Officer of Mississippi State Board of Health.

3. "Health Maintenance Organization" or "HMO" means a public or private organization which:

    a. provides or otherwise makes available to enrolled participants health care services, including substantially the following basic health care services: physician services, hospitalization, laboratory, x-ray, emergency and preventive services, and out-of-area coverage.

    b. is compensated (except for co-payments) for the provision of the basic health care services listed in paragraph (a) to enrolled participants on a pre-determined basis.

    c. provides health care services primarily:

        1. directly through providers who are either employees or partners of such organizations

        2. through arrangements with individual providers or one or more groups of providers organized on a group practice or individual practice basis.

4. "Evidence of Coverage" means any certificate, agreement, or contract issued to an enrollee setting out the coverage to which he is entitled.

5. "Enrollee" means an individual who is enrolled.

6. The HMO "Health Care Plan" or HMO "Plan" means any arrangement whereby any person undertakes to provide, arrangement whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services and at least part of such arrangement consists of arranging for health care services, as distinguished from mere indemnification against the cost of such services on a prepaid basis through insurance or otherwise.

7. "Health Care Services" means any services provided by health care providers who are licensed or otherwise credentialed under authority of state statue or services provided by health care facilities which are licensed under authority of state statue.

8. "Persons" means any natural or artificial person including but not limited to individuals, partnerships, associations, trusts, or corporations.

9. "Provider" means any natural or artificial person including but not limited to individuals, partnerships, associations, trusts, or corporations.

10. "Reinsurance" means a contract by which an organization or insurer procures a third person to insure such organization or insurer against loss or liability by reason of a risk already assumed.

Section C **-- Application for a Certificate of Authority**

1. Not withstanding any law of this state to the contrary any person may apply to the Director for a certificate of authority and upon compliance with these regulations and all applicable statutory requirements may be issued a certificate of authority to establish and operate an HMO.

2. Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Director and shall set forth or be accompanied by the following:

    a. A copy of the basic organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents and all amendments thereto.

    b. A copy of the by-laws, rules and regulations, or similar documents, if any, regulating the conduct of the internal affairs of the applicant.

c. A list of the names, addresses, and official positions of the persons who are responsible for the conduct of the affairs of the applicant, including all members of the board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association.

d. A description of the type, scope and duration of the health care services that will be rendered.

e. A copy of the any contract made or to be made between any providers or persons listed in Paragraph (c) and the applicant.

f. A copy of the form of evidence of coverage to be issued to the enrollees.

g. A copy of the form of group contract, if any, which is to be issued to employees, unions, trustees, governmental entities, or other organizations.

h. Financial statements showing the applicant's assets, liabilities, and sources of financial support including a statement as to the sources of working capital. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent (regular) certified financial statement shall be deemed to satisfy this requirement unless the Commissioner directs that additional or more recent financial information is required for the proper administration of these regulations.

i. A description of the proposed method of marketing the plan.

j. A power of attorney duly executed by such applicant, if not domiciled in this State, appointing an agent, as the true and lawful attorney of such applicant in and for this State upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this State may be served.

k. A statement reasonably describing the geographic area or areas to be served.

l. A description of the procedures and programs to be implemented to assure quality of health care.

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n. A list of all providers, giving their license number, business address, specialty

where applicable, and medical or hospital staff privileges at hospitals used or with which the HMO has a contractual arrangement; together with a description of the procedure for maintenance of a list of this information.

o. The name of the medical director.

p. A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy.

q. A statement describing the overall structure and operation of the health care plan or plans, facilities and personnel.

r. Such other information as the Director may require to make the determinations required in Section V.

s. Documentation that reinsurance contracts have been filed with the Commissioner and reviewed for adequacy.

Section D **-- Reinsurance**

An applicant or HMO shall file all contracts of reinsurance with the commissioner for review. Said contracts shall be subject to the laws of this state regarding reinsurance, if applicable, and a statement regarding the adequacy of said contracts must be obtained from the Commissioner. Reinsurance agreements shall remain in full force and affect for at least 90 days following written notice, by registered mail, of cancellation by either party to the Director.

Section E **-- Establishment of Health Maintenance Organizations**

1. On receipt of an application for a certificate of authority, the Director shall forthwith transmit copies of such application and accompanying documents to the Commissioner.

2. The Commissioner shall inform the Director within thirty (30) days of the receipt of the application, whether the health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and preenrollees. In making this determination, the Commissioner may consider, but shall not be limited to, the following factors:

   a. The financial soundness of the health care plan's arrangements for health care services and the schedule of charges used in correction therewith;
   b. The adequacy of working capital;
   c. Any agreement with an insurer, a hospital or medical service corporation, a

government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the health maintenance organization; and

d. Any agreement with providers for the provision of health care services.

3. The Director shall determine whether the applicant for a certificate of authority:

   a. Has demonstrated the legal qualifications and potential ability to provide such health care services as it proposes to provide such health care services as it proposes to provide in a manner enhancing availability, accessibility and continuity of health service to all enrollees;
   b. Has arrangements, for an on-going quality assurance program concerning health care process and the outcomes of such care;
   c. Has the ability to collect, compile, evaluate and report statistics relating to the (a) cost of its operations, (b) the patterns of utilization of its services, (c) the availability and accessibility of its services and (d) such other matters as may be reasonably required by the Director.

4. Within 60 days of receipt of the application the Director shall issue a certificate of authority to the HMO or deny said certificate and notify the applicant that the health maintenance organization does not meet requirements, specifying in what respects the application is deficient.

Section F **-- Notification of Material Changes or Modifications:**

A health maintenance organization shall, unless otherwise provided for, file with the Director a notice describing any material modification in the information required in subsections 3 (2) (d), (f), (g), (k), (l), (m), (o), (p), and (s). Such notice shall also be filed reflecting any change of ownership or control. Notices required by this section shall be filed 30 days prior to said change. If the Director notifies the applicant that the proposed modification does not meet the requirements of Section 3 or further information is required, the HMO shall correct any deficiencies and resubmit its notice within 15 days.

Section G **-- Fiduciary Responsibilities**

1. Any director, officer, employee or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of such organization shall be responsible for such funds in a fiduciary relationship to the enrollees and organization.

2. A health maintenance organization shall maintain in force a fidelity bond purchased from

a company licensed to do business in this state on employees, directors, partners and officers in an amount not less than $100,000 or such greater sum as may be prescribed by the Director. All such bonds shall be written with at least a one-year discovery period and shall be written with at least a on-year discovery period and shall contain a provision that no cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, shall take effect prior to the expiration of 90 days after written notice of such cancellation or termination is approved by the Director.

Section H **-- Evidence of Coverage and Charges for HMO Health Care Services**

1. a. Every enrollee residing in this State is entitled to an evidence of coverage under a health care plan. If the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a hospital or medical service corporation shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage.

   b. No evidence of coverage, or amendment thereto, shall be issued or delivered to any person in this State until a copy of the form of the evidence of coverage, or amendment thereto, has been filed with and approved by the Director. If the Director does not disapprove an evidence of coverage, or amendment thereto, within 30 days of filing, it shall be deemed approved.

   c. An evidence of coverage shall contain:

      i. A clear and concise statement, if a contract, or a contract, or a reasonably complete summary, if a certificate, of:

         A. The health care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health care plan;
         B. Any limitations on services, kind of services, benefits or kind of benefits to be including any deductible or copayment feature;
         C. Where and in what manner information is available as to how services may be obtained and
         D. A clear and understandable description of the health maintenance organization's method for resolving enrollee complaints and a statement that each enrollee may forward complaints directly to the State Department of Health.

      ii. No provision or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation, or which are untrue, misleading or deceptive as defined in Section 13.

iii. Subsequent changes may be evidenced in a separate document issued to the enrollee.

2. A schedule of charges for enrollee coverage for health care services, or amendment thereto, shall be filed with the Director.

3. The Director may require the submission of whatever relevant information he deems necessary in determining whether to approve or disapprove a filing made pursuant to this Section.

Section I -- Annual Report

1. Every HMO shall annually, within 90 days of the end of its operating year, file a report with the Director covering the preceding calendar year, verified by at least two principal officers.

2. Such report shall be on forms prescribed by the Director and shall include:

   a. A financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year certified by an independent public accountant;
   b. Any material changes in the organization submitted pursuant to Section 3 (2);
   c. The number of persons enrolled during the year, the number of enrollees as of the end of the year and the number of enrollments terminated during the year;
   d. A summary of information compiled pursuant to Section 3 in such form as required by the Director; and
   e. Such other information relating to the structure and operation of the health maintenance organization as is necessary to enable the Director to carry out his duties under these regulations.

Section J -- Annual Statement to Enrollees

Each health maintenance organization shall make available upon request to each enrollee the most recent annual statements of financial condition, balance sheet and summary of receipts and disbursements.

Section K -- Complaint System

1. a. Every health maintenance organization shall maintain a complaint system which has been filed with and approved by the Director after consultation with the Commissioner which provides reasonable procedures for the resolution of written complaints initiated by enrollees concerning health care services.

   b. Each health maintenance organization shall maintain records of written complaints filed with it concerning provision of health services and provider relationships.

   c. Such reports and records enumerated in (b) and (c) shall be made available to the Director or his designee upon his request or inspection at any time upon providing reasonable notice to the Medical Director and shall include:

      i. A description of the procedures of the complaint system;
      ii. The total number of complaints handled through such complaint system and a compilation of causes underlying the complaints filed and
      iii. The number, amount and disposition of malpractice claims made by enrollees of the organization against any providers which were settled by the health maintenance organization during the year.

Section L -- Protection Against Insolvency

1. In order to obtain a certificate of authority an applicant must demonstrate capital of the greater of

   a. 5% of its estimated expenditures for health care services for its first year of operation or
   b. $100,000

2. Each health maintenance organization that obtains a certificate of authority shall have and maintain a capital account of at least $100,000. The capital account shall be net of any accrued liabilities and be in the form of cash, securities or any combination of these or other measures acceptable to the Director.

3. Pursuant to Section 4, prior to obtaining a certificate of authority an applicant must demonstrate that it has obtained reinsurance, and that all contracts of reinsurance have been filed with an reviewed by the Commissioner. Any agreement between the applicant and insurer shall be subject to the laws of this state regarding reinsurance. All reinsurance agreements and any modifications thereto must be reviewed by the Commissioner. Reinsurance agreements must remain in full force and effect for at least 90 days following written notice by registered mail or cancellation by either party to the Director.

4. In order to obtain a certificate of authority an applicant must demonstrate that the persons

responsible for the conduct of the affairs of the applicant are competent, trustworthy and possess good moral character.

Section M -- Deceptive Practices

No health maintenance organization, or representative thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of this act:

1. An enrollee may not be cancelled or denied renewal except for reasons stated in the rules of the health maintenance organization applicable to all enrollees, for failure to pay the charge for such coverage or for such other reasons as may be promulgated by the Director.

2. No health maintenance organization unless licensed as an insurer may refer to itself as an insurer or use a name deceptively similar to the name or description of any insurance or surety corporation doing business in this state.

Section N -- Examinations

1. The Director may make an examination of the affairs of any health maintenance organization as often as he deems it is reasonably necessary for the protection of the interests of the people of this State but not less frequently than once every three (3) years.

2. The Director may make such reasonable examination concerning the quality of health care services of any health maintenance organization and providers with whom such organization has contracts, agreements, or other arrangements pursuant to its health care plan he deems is reasonably necessary.

3. Every health maintenance organization and provider shall submit its relevant books and records relating to the health care plan for such examinations and in every way facilitate said examinations.

Section O -- Denial, Suspension or Revocation of Certificate of Authority

1. The Director may deny, suspend or revoke any certificate of authority issued to a health maintenance organization if he finds:

    a. the health maintenance organization is operating in a manner contrary to that

described in the information submitted under Section 3, unless amendments to such submissions have been filed with the Director; or

b. The evidence of coverage or schedule of charges for health care services do not comply with the requirements of Section 8, or

c. The health maintenance organization does not provide or arrange for:

i. The basic health care services as defined in Section 2 (3) (a); or
ii. It is unable to fulfill its obligations to furnish health care services as required under its health care plan.

d. The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees; or

e. The health maintenance organization has failed to implement the complaint system in a manner reasonably intended to resolve valid complaints; or

f. The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner; or

g. The continued operation of the health maintenance organization would be hazardous to its enrollees; or

h. The health maintenance organization has otherwise failed to substantially comply with these regulations.

2. When the certificate of authority of a health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees except newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.

3. When the certificate of authority of a health maintenance organization is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to discontinue operation, and shall conduct no further business except as any be essential to the orderly conclusion of the affairs of such organization. It shall engage in no further advertising or solicitation whatsoever. The Director may, by written order, permit such further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

Section P -- Administrative Proceedings

1. When the Director has cause to believe that grounds for the denial of an application for a certificate of authority exist, or that grounds for the suspension or revocation of a certificate of authority exist, he shall notify the health maintenance organization and where questions regarding reinsurance exist he shall notify the Mississippi Insurance Commission in writing stating the grounds for denial, suspension, or revocation and notify the applicant of a hearing to be held not more than twenty (20) days thereafter on the matter.

2. The hearing shall be held before the Director, or his designated representative. After such hearing, or upon the failure of the health maintenance organization to appear at such hearing, the Director shall take such action as is deemed advisable on written findings which shall be mailed to the applicant and the Insurance commission. The action of the Director shall be subject to review by the Chancery Court of the First Judicial District of Hinds County, Mississippi.

Section Q -- Confidentiality of Patient Information

Any data or information pertaining to the diagnosis, treatment, or health of any enrollee obtained from such person or from any provider by a health maintenance organization shall be held in confidence and shall not be disclosed to any person except:

a. to the extent necessary to carry out the purposes of these regulations; or
b. upon the express consent of the enrollee or applicant; or
c. pursuant to statute or court order for the production of evidence or the discovery thereof; or
d. in the event of a claim or litigation between such person and the health maintenance organization wherein such data or information is pertinent.

A health maintenance organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the health maintenance organization is entitled to claim.

Section R -- Insolvency, Liquidation, Rehabilitation, Conservation

1. The Director may deem an HMO insolvent when it is not possessed of assets at least equal to all liabilities.

2. Assets shall mean all property, real, personal or otherwise, no specifically mortgaged,

pledged, deposited or otherwise encumbered of the security or benefit of specific persons or a limited class or classes or persons, and as to such specifically encumbered property the term includes all such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. General assets held on deposit or in trust for the security or benefit of all policy holders shall be deemed assets pursuant to this section.

3. Proceedings to liquidate, rehabilitate or conserve the assets of an HMO may be commenced against an HMO doing business in this State by the Director upon reasonable belief of insolvency or pursuant to the criteria set out in Sub-section (b).

   a. The Director shall commence said proceedings by application to a Court of competent jurisdiction for an order directing the HMO to show cause why the Director should not have the relief sought.

   b. The Director may apply to the Court for an order appointing him in his official capacity and his successors in office, or his authorized designee, as Trustee of any HMO doing business in this State upon one or more of the following grounds. That the HMO:

      i. Is insolvent;
      ii. Has refused to submit any of its books, records, accounts, or affairs to reasonable examination by the Director or his designee;
      iii. Has failed to comply with an order of the Director to make good an impairment of capital.
      iv. Has transferred or attempted to transfer substantially its entire property or business, or has entered into any transaction the effect of which is to merge substantially its entire property or business in that of any other insurer without first submitting the required notice;
      v. Has willfully violated its charter or articles of incorporation or any law of this State;
      vi. Has an officer, director, or manager who has refused to be examined under oath concerning its affairs;
      vii. Has been or is the subject of an application for the appointment of a receiver, trustee, custodian, or sequestrator of the HMO or its property otherwise than pursuant to the provisions of these regulations;
      viii. Has consented to such order through a majority of its directors, stockholders, members or subscribers;
      ix. Has ceased transacting business; or
      x. Any circumstances jeopardizing the interest of consumers of this state.

   c. Upon appointment as trustee by a court of competent jurisdiction, the Director shall take possession of the property of the HMO, deal with the HMO's property and business in his or her own name as Director or in the name of the HMO, give

notice to all creditors who may have claims against the HMO to present such claims, liquidate said business, and otherwise exercise all powers available to him under the laws of this state.

d. In any proceeding initiated pursuant to these regulations the following priority of claims in the distribution of assets will serve as a guideline:

1. claims for cost of liquidation
2. compensation actually owing to employees other than officers of the HMO
3. claims of enrollees
4. claims of general creditors

Section S **-- Savings Clause**

If any section, subsection, word, phrase or clause of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the sections, subsections, words, phrases or clauses of the regulations which can be given effect without the invalid section, subsection, word, phrase or clause, and to this end the sections, subsections, words, phrases, and clauses of these regulations are declared to be severable.